artery was noted in case of re-do procedures, though vessel wall irregularities was noted in few cases.
Conclusion: Postprocedural patency in radial interventions depends upon the nature and complexity of the coronary disease. Females were more prone to develop puncture site complications. Tobacco usage has the strongest association with the postprocedural non-patency, followed by dyslipidemia. In diabetics, mean internal radial diameter was found to be low, whereas hypertension was not associated significantly with the non-patency. Patency was higher in taller persons or with larger BSA, but less in short or in lean and thin persons, or with smaller BSA. More the wrist diameter or circumference, greater was the chances of patency. Presence of pulse does not always indicate the artery is patent, as presence of good collaterals to maintain circulation may give rise to palpable pulse. Whereas absence of pulse always indicates that there is significant flow reduction or non-patency. There is negligible chance of developing non patent radial artery in cases of repeat procedures provided case selection is done by maintaining the above mentioned exclusion criteria. Re-do procedure does not cause reduction in the internal diameter of the artery.

EVAR in abdominal aortic aneurysm – A single center experience

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Background: The safety and efficacy of everolimus eluting bioabsorbable vascular scaffold (BVS) in the management of "ST" elevation myocardial infarction (STEMI) is yet to be established.
Aims: To evaluate immediate and short-term safety and efficacy of the everolimus-eluting BVS compared with non BVS drug eluting stent (DES) in patients with STEMI.
Methods: From January 2013 to December 2014, 220 patients with STEMI were included in this study. Among them, 35 patients treated with BVS were compared with a control group composed of 180 consecutive patients who underwent non BVS DES implantation in the same time period. The incidence of major adverse cardiac events (MACE: stent thrombosis: death, non-fatal myocardial infarction, or reintervention) before discharge and up to six months was evaluated.
Results: Single vessel disease was more frequent whereas, double and triple vessel disease was less frequent in BVS group. Procedural characteristics were also similar between groups, except for the use of post dilation ($p = 0.04$). Procedural success, in-hospital, and up to six-month MACE rates were similar between both groups. Definite or probable in-stent/scaffold thrombosis did not occurred in BVS patients, though two patients during the index admission and another two patients in the first month after DES implantation had stent thrombosis.
Conclusion: The use of the Absorb BVS in this cohort reflecting day-to-day real world clinical practice is feasible and associated with good procedural safety, and angiographic success rate.

Outcome of Everolimus eluting bioabsorbable vascular scaffold (BVS) in the management of ST-segment elevation myocardial infarction (STEMI) – A prospective observational study

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Background: Although recent studies have demonstrated the safety and efficacy of everolimus eluting bioabsorbable vascular scaffold (BVS) in the management of stable coronary artery disease (CAD), but there is lack of data regarding use of BVS for primary percutaneous coronary intervention (PCI) in management ST segment elevation myocardial infarction (STEMI).
Aims: To evaluate immediate and short-term safety and efficacy of the everolimus-eluting BVS in patients with STEMI.
Methods: From January 2013 to December 2014, patients with STEMI who received BVS implantation during primary PCI were included in this study.
Results: Among 220 patients of primary PCI, 35 patients received BVS stent within this study period. Mean age was 59.2 ± 9 years. Mean duration of follow-up was 11.5 ± 5 months. Eighty percent patients had single vessel CAD. Femoral access was used in 51% cases. Mean door-to-balloon time was 93 ± 30 min. Anterior wall STEMI was more frequent than inferior wall STEMI involving right coronary artery territory. Mean BVS length and BVS diameter per patient was 24.6 ± 4.7 mm and 3.2 ± 0.3 mm, respectively. About 66% patients received thrombo aspiration during PCI and thrombolysis in myocardial infarction (TIMI) III flow was achieved in 94% patients. Procedural success was achieved in 94% of the cases. Only one case had non-cardiac death within one month.
Conclusion: The use of the Absorb BVS in this cohort reflecting day-to-day real world clinical practice is feasible and associated with good procedural safety and angiographic success rate.

360 degree ACS intervention

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Case history: A 61-year-old male; Diabetes Mellitus on OHA; K/C/OMinor CAD (CAG in 2012); Presented with Acute Infero Posterior wall MI, taken up for Primary Angio Plasty elsewhere, deferred due to complex anatomy, was thrombolyzed and referred to our hospital for further management.
Techniques/hardware attempted: Guides: JR, AL1, 2; Wires: BMW, Fielder XT, Grand Slam; Balloon: 1.25, 1.5, 2, 2.5, NC; Stent: 2.75×15, 3×15; Microcatheter: Fine Cross 1.7F; Guideliner: 6F.
Techniques: Double Wire; Conal Artery balloon occlusion; Double catheter/double wire technique; Double catheter + guideliner + grandslam.
Take home message: Tortuosity is always a night mare; Double GUIDE concept changes device interactions dramatically; Amplatz Guide + Guideliner + 2 Grandslam provide incremental support; Even in ACS, hardware choice and Bigger Shelf support matters.

Provisional observation of FFR outcome proves utility in ambiguous vessel abnormality

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Introduction: Fractional flow reserve (FFR) is a very handy tool to determine the precise hemodynamic significance of intermediate epicardial coronary artery stenosis and thus to take appropriate clinical judgment. Several trails already have identified its utility in different clinical set up and parameters but it is still to be adopted as must have tools in Indian Interventional Niche